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# Exhibit

# A

Gulf Pines Hospital Records  
Of Derrick Charles

No. 941969A

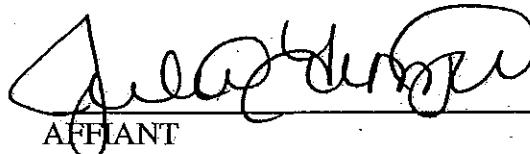
THE STATE OF TEXAS § IN THE 184<sup>th</sup> DISTRICT  
VS. § COURT IN AND FOR  
Derrick Charles § HARRIS COUNTY, TEXAS

**AFFIDAVIT**

Before me, the undersigned authority, personally appeared Julie Timpe who, being by me duly sworn, deposed as follows:

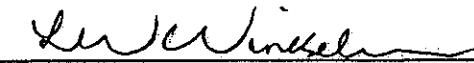
My name is Julie Timpe, I am of sound mind, capable of making this affidavit, and personally acquainted with the facts herein stated:

I am the custodian of records of The Brown Schools. Attached hereto are 242 pages of records from The Brown Schools. These said 242 pages of records are kept by The Brown Schools in the regular course of business, and it was the regular course of business of The Brown Schools for an employee or representative of The Brown Schools, with knowledge of the act, event, condition, opinion or diagnosis, recorded to make the record or to transmit information thereof to be included in such record; and the record was made at or near the time or reasonably soon thereafter. The records attached hereto are exact duplicates of the original.

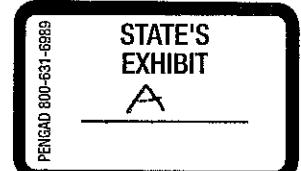


AFFIANT

SWORN AND SUBSCRIBED to before me, the undersigned authority, while engaged in, and related to, the performance of my duties as a peace officer on this the 11<sup>th</sup> day of March, 2005.



Larry Winkelmann, Investigator  
Harris County District Attorney's Office  
Houston, Texas



HOUSTON TEXAS

77090

HOLD DATE

1 MEDICAL RECORD NO.

004834

BILLING NO.

431716

3 A/R NO.

431716

4 PATIENT'S LEGAL NAME (L/F, MI)  
CHARLES DERRICK

5 SEX

M

6 RACE

B

7 BIRTHDATE

09-06-1982

8 AGE

010

9 HEIGHT

10 WEIGHT

11 SS

12 MS

5

13 RELIGION/CHURCH

14 PATIENT'S LEGAL NAME (L/F, MI)  
CHARLES DERRICK

15 ADDRESS

1601 IMPERIAL VALLEY

#227

CITY/STATE

HOUSTON

ZIP=77060

16 TELE

713

TX445-5617

17 ES 18 PATIENT'S EMPLOYER

21 SOCIAL SECURITY NO.

22 EMPLOYEE ID

23 LOE

19 EMPLOYER ADDRESS

CITY/STATE

20

TELE

24 RESPONSIBLE PARTY

25 PHILLIPS NANCY

24 OCCUPATION

25

CITY/STATE

ZIP=77060

32 TELE

713

TX445-5617

33 ES 34 RESPONSIBLE PARTY'S EMPLOYER

26 SOCIAL SECURITY NO.

27 EMPLOYEE ID

28 LOE

26 RESPONSIBLE PARTY'S ADDRESS

27

CITY/STATE

ZIP=77060

32 TELE

713

TX445-5617

29 TOTAL DAYS:

30 DATE OF ADMISSION:

3/9/93

31 HOUR OF ADMISSION:

32 TOTAL HOURS:

33 DATE OF DISCHARGE:

3/11/93

34 HOUR OF DISCHARGE:

35 ADMITTING PHYSICIAN:

## FINAL DIAGNOSES

AXIS I:

Oppositional Defiant Disorder  
Depressive disorder, NOS

CODES

313.81  
296.20

AXIS II:

No dx

AXIS III:

R10 Partial Complex Symptom Disorder

AXIS IV:

3

AXIS V:

GAF - 45 on discharge

ADMITTING  
DIAGNOSES  
CODES:

## DISCHARGE STATUS:

 HOME 01  
 OTHER HOSPITAL 02

 SNF 03  
 ICF 04  
 HOME HEALTH 06  
 AMA 07  
 EXPIRED 20  
 OTHER 05

PROCEDURES/OTHER:

CONSULTANTS:

I HAVE EXAMINED AND APPROVED THIS COMPLETE MEDICAL RECORD

PHYSICIAN SIGNATURE

3/11/93

DATE

HCA GULF PINES HOSPITAL

DISCHARGE SUMMARY

PATIENT NAME: DERRICK CHARLES DATE OF ADM: 03/09/93  
PATIENT NO: 00-48-34 DATE OF DIS: 03/11/93  
ATTENDING PHYSICIAN: LAWRENCE D. GINSBERG, M.D.

ADMITTING DIAGNOSES:

Axis I: Oppositional Defiant Disorder  
Depressive Disorder, Not Otherwise Specified  
Axis II: No Diagnosis  
Axis III: Rule Out Partial Complex Seizure Disorder  
Axis IV: (3)  
Axis V: GAF - 30 - On Admission

FINAL DIAGNOSES:

Axis I: Oppositional Defiant Disorder  
Depressive Disorder, Not Otherwise Specified  
Axis II: No Diagnosis  
Axis III: Rule Out Partial Complex Seizure Disorder  
Axis IV: (3)  
Axis V: GAF - 45 - On Discharge

REASON FOR ADMISSION: This is the first HCA Gulf Pines Hospital admission for this 10 year old Black male. The patient was initially evaluated in the office on the day prior to admission in the presence of his mother and stepfather. The patient had been violent towards his peers at home and at school. He had been depressed. In school the patient lost his temper, argued with adults, refused chores. He was easily annoyed, he was angry and resentful and blamed others for his actions. He had witnessed violent behavior between mother and stepfather. The patient had been suspended from school. The patient was admitted because of serious dysfunctionality at home and at school.

MENTAL STATUS EXAMINATION ON ADMISSION: The patient was casually dressed. He was not verbal. His affect was blunted. His mood was depressed. His associations and thought processes were appropriate. There was no evidence of delusions, hallucinations, or suicidal ideations. His short term memory was fair to good. His orientation was X 3. He was alert. His intellectual functioning was good.

HCA GULF PINES HOSPITAL  
DISCHARGE SUMMARY

PATIENT NAME: DERRICK CHARLES

PAGE 2

PHYSICAL EXAMINATION ON ADMISSION: As per Dr. James P. Zucconi. Skin showed some dryness as well as ~~on~~ <sup>posterior</sup> the elbows and anterior knees. Heart rate was 66. Respiratory rate was 14. He had some slurring of speech but was understandable. The rest of examination was unremarkable.

LABORATORY DATA: March 10th, urine drug screen was negative. March 10th, urinalysis was within normal limits except for 1+ mucous. CBC was within normal limits. Chemistries were within normal limits except for total bilirubin of 1.3, total cholesterol of 218, LDL cholesterol 137. Hypothyroid panel was within normal limits. RPR was non-reactive. Folic acid level and Vitamin B12 level was within normal limits. Electrocardiogram on admission revealed sinus rhythm, QT 0.36.

HOSPITAL COURSE: The patient was treated on the Children's Psychiatric Unit with daily physician visits, individual therapy, family therapy, group therapy, activities therapy, and biofeedback. On the second day of admission patient's mother because she missed her child signed a 24 hour letter requesting discharge. The patient was discharged the following day by Art Smith, M.D. who was on call for me.

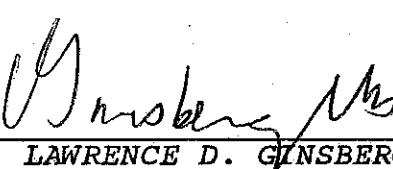
PROGNOSIS ON DISCHARGE: Is fair only with continued treatment.

DIET ON DISCHARGE: Regular.

PHYSICAL ACTIVITY: No restrictions.

MEDICATIONS ON DISCHARGE: None.

AFTERCARE: Dr. Smith instructed the patient's family to call me with regard to outpatient follow up. The patient's family will be instructed to repeat his bilirubin level as an outpatient.

  
LAWRENCE D. GINSBERG, M.D.

LDG:ld

DD: 04/06/93

DT: 04/07/93

HCA Gulf Pines Hospital

205 Hollow Tree Lane  
Houston, Texas 77090  
Telephone (713) 537-0700

## DISCHARGE

## SUMMARY/PLAN

CHARLES DERRICK 10  
M 09061962 050993  
GINSBERG 160

## NURSING DISCHARGE SUMMARY

## GENERAL INFORMATION

Date of Discharge 3/11/93 Time \_\_\_\_\_Discharge Status:  MD Order  AMA  AMA Release SignedMode of Discharge: ambulatoryAccompanied by: Name Nancy Phillips Relationship mother

## CONDITION OF PATIENT ON DISCHARGE

## MEDICAL STATUS:

stable

## EMOTIONAL STATUS:

bright

## MEDICATIONS

Prescriptions to Patient/Other:  Yes  No  Nonapplicable

List Medications:

NAME	DOSAGE	FREQUENCY
<u>NONE</u>		

Psychotropic Medication Management Information provided to patient/other via Medication Teaching Sheet(s).  Yes  NoPatient/Other instructed to contact physician/pharmacist for information concerning prescribed NON-psychotropic medications.  Yes  No

## SPECIFIC INSTRUCTIONS/TEACHING

NONE

## RESTRICTIONS:

reg

## PHYSICAL ACTIVITY

as tolerated

## SIGNATURES

Above information has been explained to me and I understand the contents.

X Nancy Phillips 3-11-93  
Patient/Significant Other Relationshipm Jackson ENC 3/11/93  
Nurse Date

## SOCIAL SERVICE DISCHARGE PLAN

## LIVING ARRANGEMENTS FOLLOWING DISCHARGE

With Whom/Name of Facility mother - Nancy Phillips

Address \_\_\_\_\_

## FOLLOW UP CARE

Community Agency/Individual recommended for aftercare:

Name R.D. Ginsberg Phone # 893-4111

Address \_\_\_\_\_

Initial Appointment Date call DR. Monday

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

Initial Appointment Date \_\_\_\_\_

## Support Groups:

 AA  NA  CA  GPH Aftercare  Multi-Family

Other \_\_\_\_\_

## Comments:

Tues 7-8 parent support  
Wed 630-730 parenting skills

## SCHOOL/VOCATIONAL/WORK/PLAN

## OTHER SIGNIFICANT INFORMATION

Patient/Other Instructed to contact \_\_\_\_\_  
should assistance be required following discharge.SATISFACTION SURVEY COMPLETED  YES  NOI give permission for Gulf Pines Hospital to contact me at  Home/  
 Work, for a period not to exceed 6 months to determine my satisfaction  
with services provided. I can be contacted at \_\_\_\_\_  
between the hour \_\_\_\_\_ and \_\_\_\_\_

Signed: \_\_\_\_\_

## SIGNATURES

Above Information has been explained to me and I understand the contents.

X Nancy Phillips 3-11-93  
Patient/Significant Other Relationship Date

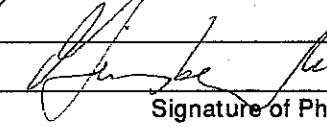
Signature of Social Worker

Signature of Psychiatrist

DATE 3/8/93TIME 1600LOCATION ROPA

## FINDINGS/RECOMMENDATIONS:

pt is violent & psychotically altered  
 + depression - likely improved - sign for global  
 Admission advised

  
 Signature of Physician

## PHYSICIAN ADMITTING NOTE/PRELIMINARY PSYCHIATRIC ASSESSMENT/TREATMENT PLAN

## JUSTIFICATION FOR ADMISSION

Patient must meet one or more of the following criteria. Check applicable item(s).

- a. Recent suicide attempt (within 72 hours) or suicidal ideation requiring suicide precautions.
- b. Physically assaultive behavior threatening the life or safety of other persons.
- c. Self-mutilating behavior.
- d. Acute onset or exacerbation of psychotic symptoms (hallucinations, delusions, disordered thinking) of sufficient severity to jeopardize the patient's ability to live safely outside of a hospital.
- e. Acute deterioration of patient's behavior, coping skills or ability to care for self that creates a risk of harm to self or other persons.
- f. Acute onset of severe mental anguish that overwhelms the patient to the extent that the patient cannot function outside of a hospital.
- g. Meets DSM-III-R criteria for Major Depression (documented in Psychiatric Assessment).
- h. Meets DSM-III-R criteria for Mania (documented in Psychiatric Assessment).
- i. Meets DSM-III-R criteria for alcohol withdrawal delirium (documented in Psychiatric Assessment) or is in impending alcohol withdrawal delirium based on a history of severe alcohol dependence and abrupt cessation of alcohol intake.
- j. Severely disabled as a result of psychoactive substance-induced withdrawal, delirium, delusional disorder or amnestic disorder (DSM-III-R criteria documented in Psychiatric Assessment).
- k. Patient requires inpatient treatment and rehabilitation for psychoactive substance dependence based on:
  - (All four of the following must be met)
  - 1) extensive or prolonged use of psychoactive substance(s); and
  - 2) significant impairment of health or of family, social, occupational or academic functioning as a result of substance dependence; and
  - 3) complicating medical problems (including residual impairment secondary to psychoactive substance withdrawal, delirium, delusional disorder or amnestic disorder) or failure of a structured outpatient rehabilitation program to achieve abstinence from psychoactive substances; and
  - 4) a reasonable medical expectation that inpatient treatment and rehabilitation will improve the patient's ability to maintain abstinence from psychoactive substances upon which the patient is dependent.
- l. Patient requires inpatient treatment and rehabilitation for psychoactive substance dependence based on a reasonable medical determination that such inpatient treatment and rehabilitation are necessary to significantly reduce the risk of:
  - 1) rapid deterioration of patient's behavior, coping skills, or ability to care for self that creates risk of harm to self or other persons; or
  - 2) relapse or continuing psychoactive substance use resulting in significant impairment of health or of family, social, occupational, or academic functioning.
- m. Other \_\_\_\_\_

IMPORTANT: EACH CRITERION CHECKED ABOVE MUST BE REFLECTED  
IN THE PATIENT'S PSYCHIATRIC ASSESSMENT.

(CONTINUED ON BACKSIDE OF FORM)

**HCA** Gulf Pines  
Hospital
Rev. 7-92  
700-020

43171b

CHARLES DERRICK 10  
M 09061982 030993  
GINSBERG 160

1. Chief complaint (in patient's own words if possible) violent behavior / severe oppositional behavior2. History of present illness including alcohol/drug use and precipitants justifying hospitalization: violent towards parents & in school. Aggressed at school, threw paper, argues with adults, refuses chores, talky & easily annoyed, angry & irritable, blames others. Has inattentiveness & hyperactivity. Violent behavior towards each other. Now suspended from school3. Known physical status and allergies: had a seizure at 8 weeks of age. Recurrent fevers. Stomach aches. Colic when born 3 months ago

4. Brief mental status:

a. General appearance/behavior casually dressed, relatively uninvolved

b. Affect/Mood offered breakfast. Food depressed

c. Associations and thought processes appropriate

d. Thought content and structure (including delusions, hallucinations/suicidal ideation) No delusions/hallucinations. Suicidal thoughts

e. Cognitive functions:

- Memory short term fair to good
- Orientation X 3
- Intellectual functioning good

5. Inventory of patient's assets Family supportive of fx6. Provisional Diagnosis: Axis I. Oppositional Defiant Disorder, Major Depressive Disorder, NOSAxis II. No dxAxis III. PTSD history of rape by ex-husband7. Criteria for Discharge enthusiastic, violent behaviorreturn into family dynamics8. Projected length of stay 2-3 wks9. Preliminary discharge plan have US RTC

10. Physician preliminary plan of care:

## Focus of Treatment

## Goals

<u>violent behavior</u>	<u>elation</u>
<u>depressing</u>	<u>enthusiasm</u>

<u>DR. XIAO JIAO</u> <u>889030 58934</u> <u>091 08302410</u>	<u>Admitting Physician</u>	<u>3/9/09</u>	<u>1315</u>
		<u>Date</u>	<u>Time</u>

Attending Physician

Date

Time

**Gulf Pines  
Hospital****PHYSICIAN ADMITTING ORDERS - CHILDREN'S PROGRAM****I. THE HISTORY AND PHYSICAL** is to be completed within 24 hours by: Attending Physician Other (please name) Vaccination**II. VITAL SIGNS** Routine Special (indicate frequency) g Shift**III. LAB AND RADIOLOGY** Care Panel CBC w/DIFF. Hypothyroid Panel (T4, T3 Uptake, FTI, TSH) Comprehensive Toxicology UA RPR Urine Pregnancy EKG Other: B12 level, Vit B12 level, Serum GlucoseStress ECG**CLINICAL JUSTIFICATION (s)** R/O Metabolic Disorder R/O Infectious Disease R/O Pregnancy R/O Toxicity Other: R/O organic disorder**IV. DIET:**  Regular Special (SPECIFY): \_\_\_\_\_**V. PRECAUTIONS** No Precautions Suicide (15 min. checks) Seizure/Medical (30 min. checks) Assault/Homicidal (15 min. checks) Detox (30 min. checks) Elopement (15 min. checks)**CLINICAL JUSTIFICATION (s):** Has been assaultive at home + school**VI. THERAPEUTIC RESTRICTIONS** No Restrictions Unit Restriction (7-Day Expiration) Indoor Facility Restriction (3-Day Expiration) Physical Search for Contraband**CLINICAL JUSTIFICATION (s):** \_\_\_\_\_**VII. THERAPEUTIC COMMUNICATION LIMITATIONS (ALL EXPIRE IN 7 DAYS)** No Limitations Telephone Mail Visitors**CLINICAL JUSTIFICATION (s): SPECIFY EXACT LIMITATIONS, (eg. when limited from telephone, what mail/visitors are limited), DURATION OF LIMITATIONS, AND JUSTIFICATION FOR EACH LIMITATION)** \_\_\_\_\_

(Continued on back)

43171b

CHARLES DERRICK 10  
M 09061982 030993  
GINSBERG 160

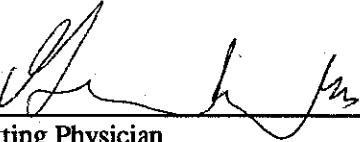
**VIII. ASSESSMENT ORDERS**

Psychosocial Assessment  
 Psychological Evaluation, by whom: \_\_\_\_\_  
 Educational Assessment, by whom: \_\_\_\_\_  
 Other: \_\_\_\_\_

Full Battery  Brief Battery  
 Karen Redus, Psy.D. *notified*

**IX. THERAPY ORDERS**

Assessment Program:

 SUCCESS RT ROPES Individual Therapy/Program Counseling; by whom: Sandra Hoane, LPC *notified* Family Therapy/Family Program Counseling; by whom: Sandra Hoane, LPC Other: Tai Chi Other: \_\_\_\_\_  
Admitting Physician

Date

3/9/93  
Attending Physician

Date

noted in Jackson etc  
Signature of Nurse3/9/93  
Date

JULIE P

01 X014830 231-440  
522050 58-13-61 M  
00 0X182210

AFTER DOCTOR WRITES A MEDICATION ORDER  
 1. Remove yellow and pink copies.  
 2. Dispatch yellow copy to the Pharmacy and the pink copy to the Medication Nurse.  
 3. After copy 3 is used "X" out remaining unused lines.

## Use Ball Point – Press Firmly

Another brand of a generically equivalent product, identical in dosage form and content of active ingredient(s) may be administered if column is not checked

DATE	TIME	ORDERS
3/9/93	1315	Admit to Unit 5 - Rydell's Unit <input checked="" type="checkbox"/> (1) Oppositional Defiant Disorder <input checked="" type="checkbox"/> (2) Major Depressive Disorder, NOS  Exacerbate maladjusts Broke back 32 weeks.  <input checked="" type="checkbox"/> Typhal 15 grs 940 PM fecal softener <input checked="" type="checkbox"/> Typhal 15 cc po bid PRN constipation <input checked="" type="checkbox"/> Typhal 15 cc po q80 PRN indigestion  Child Psychiatry Cptd to Buffalo notified Pending M/S
3-10-93	200 charts / E. Bochner	noted 3/9/93 1550 4th Jackson ext
3/10/93 0915		Dr sent to care 3/10/93 5PM to 3/15/93 7AM 3/10 0930 to Eastman Hospital

ICANUM-10461A

NKA

Height: 5'4"  
 Weight: 77 lbs

PATIENT INFORMATION

431716

CHARLES PERLICE 19  
 # 09061962 039913  
 GINSBERG 148

004834 85

① Oppositional Defiant Disorder  
 ② Major Depressive Disorder  
 NOS

diff16#

OF 8318600 23 JUN 3  
1990 80976040 2  
601 8318600

60 8318600

#### AFTER DOCTOR WRITES A MEDICATION ORDER

1. Remove yellow and pink copies.
2. Dispatch yellow copy to the Pharmacy and the pink copy to the Medication Nurse.
3. After copy 3 is used "X" out remaining unused lines.

## **Use Ball Point – Press Firmly**

Another brand of a generically equivalent product, identical in dosage form and content of active ingredient(s) may be administered if column is not checked

## **ALLERGIES**

## PATIENT INFORMATION

43178

CHARLES DERRELL 16  
# 69061982 830973  
GINSBERG 160

difficult

or X318230 8502400  
899650 8502400 8  
841 8838400  
81 8838400

88 8838400

**DISCHARGE ORDERS**

Patient to be discharged on 3/11/93

**TRANSITION ORDERS**

From:	Level of Care	Program	Date
TO:	Level of Care	Program	Date

Primary Discharge Diagnoses:

Axis I: (1) oppositional defiant D/o  
(2) depressive D/o - NOS  
Axis II: no dx  
Axis III: no dx

Physical Activity Limitations

none

Diet regular

Current Medications

1. ✓
2. ✓
3. ✓
4. ✓
5. ✓
6. ✓
7. ✓

May patient take home own medications?  Yes  No

Prescriptions Written?  Yes  No

Aftercare 1. Psychiatric Follow up with:

to call M. Grishberg on Mon.

2. Labs as Outpatient; Specify:

Where \_\_\_\_\_ When \_\_\_\_\_

3. IT with:

\_\_\_\_\_

4. FT with:

\_\_\_\_\_

5. Aftercare Group(s) at GPH

\_\_\_\_\_

6. Outpatient/Community Group(s); Specify:

\_\_\_\_\_

7. Other Medical Follow up with:

regular M.P.

8. Other:

Other

Physician's Signature John D. Grishberg

3/11/93 115 AM 431716  
Date Date Time

CHARLES DERRICK 10  
Time M 09061982 030993  
GINSBERG 160

Nurse's Signature J. Lewis

3/11/93 1330  
Date Date

Time 004834 US

CHARGES DERRICK 10  
M 14191385 020833  
GIBBERG 180

20 436400

ACTIVITY:  
ALLERGIES: NKA

1000 1010 1020

USE LOCAL DATE

Mr. J. P. Foster, Professor.	Mr. J. P. Foster, Professor.	Mr. J. P. Foster, Professor.
Mr. J. P. Foster, Professor.	Mr. J. P. Foster, Professor.	Mr. J. P. Foster, Professor.

卷之三

HCA GULF PINES HOSPITAL

HISTORY AND PHYSICAL

PATIENT NAME: DERRICK CHARLES DATE OF ADM: 3/9/93  
PATIENT NUMBER: 00-48-34  
ATTENDING PHYSICIAN: LAWRENCE GINSBERG, M.D.  
AUTHOR OF REPORT: JAMES P. ZUCCONI, M.D.  
DATE OF REPORT: MARCH 10, 1993

According to Derrick, who is a ten year old Black male, he is being hospitalized here at Gulf Pines Hospital for being suspended at school, talking back to teachers, and not doing work. Documentation on the chart shows oppositional behavior.

PAST MEDICAL HISTORY: This child has been well. He says there is no past psychiatric or somatic hospitalizations. He did varicella in the past. No surgeries and no past hospitalizations. No history of broken arms or lacerations.

No important dental history. Patient claims he has an allergy to chocolate and he is on no present medications.

As far as a diet, the patient does not utilize alcohol, tobacco, caffeine, or recreational drugs.

Derrick lives at home with his mother, father, and an eleven year old brother with whom he fights but according to the patient, not too bad.

REVIEW OF SYSTEMS: The skin shows some distal dryness as well as on the posterior elbows and anterior knees and Keri lotion will be applied to these areas. He has no signs of shortness of breath, difficulty with breathing, periumbilical pain, heart palpitations, vision, or hearing deficit. No complaints of chronic constipation, dysuria, ambulation, or balance problems.

On examination, the head shows no signs of trauma. Tympanic membranes and ears normal. Conjunctiva of the eyes normal as well. The pupils are equal and reactive to light and accommodation. The patient has no anterior or posterior cervical nodes palpable. The chest is clear upon auscultation. There are no rales, rhonchi, or wheezing. The abdomen is soft and there is no liver or spleen palpable. There is no heart murmur. The heart rate at 66, respiratio at 14. The patient is a non-circumcised male. Testes x 2, down and palpable. There are no signs of either axillary or genital hair appreciated. There is some enlargement of the testes and Tanner for the genitalia is stage II.

Patient is 5/5 muscle power. He can do jumping jacks, deep knee bends, walk on his heels and toes without abnormality. Romberg is negative. His finger to nose and heel to shin coordination is appropriate. (continued on page 2)

CHG

HCA GULF PINES HOSPITAL

ADMISSION PSYCHIATRIC ASSESSMENT

PATIENT NAME: DEREK CHARLES

DATE OF ADM: 03/09/93

PATIENT NO: 00-48-34

ATTENDING PHYSICIAN: LAWRENCE D. GINSBERG, M.D.

DATE OF DICTATION: 03/09/93

CHIEF COMPLAINT: Violent behavior as well as severe oppositional behavior.

HISTORY OF PRESENT ILLNESS: This is the first HCA Gulf Pines Hospital admission for this 10 year old Black male. The patient was initially evaluated in the office the day prior to admission in the presence of his mother and stepfather. The patient had been violent towards his peers at home and at school. He had been depressed in school. The patient loses his temper, argues with adults, he refuses chores, he is ~~touch~~ and easily annoyed, he is angry and resentful and blames others for his actions. He has witnessed a violent behavior between mother and stepfather. The patient has been suspended from school. The patient is admitted because of his severe dysfunctionality at home and at school.

DEVELOPMENTAL HISTORY: The patient lives with mother and stepfather and brother who is age 11. His 11 year old brother is doing well. No religious preference is noted. He is in the 3rd grade at Calvert Elementary in the Aldine Independent School District. Problems in school are as noted above.

PAST MEDICAL HISTORY: Is remarkable for seizures at eight weeks of age. The patient was premature and weighed four pounds at birth. The patient stutters occasionally when stressed. He had a left elbow iron burn three months ago.

FAMILY HISTORY: The patient has a cousin who has Attention-Deficit Disorder. Paternal uncle has sickle cell anemia. Paternal aunt has diabetes.

MENTAL STATUS EXAMINATION ON ADMISSION: The patient is casually dressed. He is relatively non-verbal. His affect is blunted. His mood is depressed. His associations and thought processes are appropriate. There is no evidence of delusions, hallucinations, or suicidal ideations. His short term memory is fair to good. His orientation is X 3. The patient is alert. His intellectual functioning is good.

ASSETS: The patient's family is supportive of treatment.

HCA GULF PINES HOSPITAL

ADMISSION PSYCHIATRIC ASSESSMENT

PATIENT NAME: DEREK CHARLES

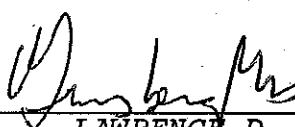
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**DYNAMIC FORMULATION:** The patient is demonstrating oppositional and defiant behaviors. In addition, it appears the patient may be depressed. He has few neurovegetative symptoms of depression but he has some depressive equivalents. In addition the patient had a seizure at eight weeks of age and has violent behaviors. The possibility of a Partial Complex Seizure Disorder cannot be ruled out.

**PROVISIONAL DIAGNOSIS:**

Axis I: Oppositional Defiant Disorder  
Depressive Disorder, Not Otherwise Specified  
Axis II: No Diagnosis  
Axis III: Rule Out Partial Complex Seizure Disorder  
Axis IV: (3)  
Axis V: GAF - 30 - On Admission

**TREATMENT PLAN:** The patient will be treated with full modalities on the Children's Unit. He will have daily physician visits, individual therapy, family therapy, group therapy, activities therapy, and biofeedback. He will have a physical examination, laboratory evaluation, and psychological testing. Medications will be deferred until evaluation is completed.

  
LAWRENCE D. GINSBERG, M.D.

LDG:1d

DD: 03/09/93

DT: 03/10/93

## PSYCHOLOGICAL REPORT

Name: Derrick Charles  
Age: 10  
Date of Birth: 9/6/82  
Date of examination: 3/10/93  
Examiner: Karan Redus, Ph.D.  
Date typed: 3/15/93

MR#: 4834

Adm: 3/9/93

### REASON FOR REFERRAL

Derrick was referred for psychological evaluation by Dr. Larry Ginsberg, M.D., after Derrick's admission to Gulf Pines Hospital. The purpose of this evaluation was to aid in diagnosis and treatment planning.

### HISTORY

It was reported that this was Derrick's first hospitalization at Gulf Pines, and that he had been admitted due to increasing behavioral problems. It was reported that he had become violent and oppositional toward peers and adults at both home and school. He apparently had been suspended from school recently. It was also reported that he was arguing with adults, refusing classes was prone to become easily annoyed, angry and resentful. Derrick reported that he had not had any behavioral problems until this year, but could not describe what if anything was different about this year in school.

It was reported that Derrick had a febrile seizure at 8 months of age. It was also reported that he walked and talked at approximately 18 months of age. No other significant illnesses or injuries were reported.

Derrick lives with his mother and stepfather, and it was reported that he had witnessed some violent behavior between them. Derrick denied the presence of hallucination, delusions or suicidal ideation.

### TECHNIQUES UTILIZED

Clinical Interview  
(Benton Visual Retention Test

Children's Apperception Test  
Projective Drawing  
Rorschach

TEST BEHAVIOR

Derrick was a 10 year old male of approximately average height and weight. He was appropriately groomed and casually dressed. He appeared cooperative as he willingly went with the examiner to the consultation room and completed all assigned tasks upon first request. However, Derrick made very little eye contact and he verbalized very little and only in response to examiner questions. During the testing on several occasions questions had to be repeated as it seemed as if he had not heard the question at all. It was not clear whether this was due to inattention, preoccupation or being unable to hear adequately. During parts of the testing Derrick worked in a deliberate and purposeful manner. In other parts of the testing he appeared to respond in a somewhat hasty and impulsive manner. For example he attempted to reach across the table for additional picture cards before the examiner could hand him the card. On other occasions he attempted to grab additional cards and give answers while the examiner was trying to inquire about a previous answer. In all instances he accepted redirection easily.

RESULTS

On the Benton Visual Retention Test he obtained an error score of 6 which was somewhat lower than would be expected given his age and level of intellectual functioning. This score indicated the absence of apparent impairments in visual memory functioning.

Personality testing suggested that he tends to intermingle feelings with thinking during problem-solving and decision-making behaviors, and that he may be more inclined to display feelings and less concerned about carefully modulating or controlling those displays. There were also indications of a laxness and apparent difficulty in modulating affect, and he may thus have difficulty dealing with emotional stimuli. In fact he may display a tendency to avoid emotional stimuli or to be uncomfortable around emotional situations. An important side effect of this tendency is that he may be avoiding or being overly cautious in many of the every day exchanges that contribute to development.

His self esteem appeared to be very low with likely feelings of being inadequate or unsuccessful. His self image is likely to include significant negative features and he may compare himself unfavorably to others. He may experience a significant sense of vulnerability. Although he may anticipate and seek harmonious interactions with others, he may also be somewhat cautious about creating and/or maintaining close emotional ties with others. In some of his responses there were themes of conflict in relationships with others, and he may see adults as being either somewhat emotionally aloof or as somewhat critical. He may struggle with angry feelings toward females. It also appeared that he may view relationships toward the world with a sense of doubt and discouragement and may tend to anticipate gloomy outcomes to his efforts regardless of the quality of that effort.

Derrick displayed a marked tendency to narrow or simplify stimulus fields. This style may promote negligence in translating information and can create the potential for a higher frequency of behaviors that do not coincide with social demands or expectations. He is likely to scan his environment in a hasty or haphazard manner and to thus miss or neglect critical bits of information, which can also lead to the risk of behaviors that do not coincide with social demands. He also displayed significant difficulty in shifting attention. It appeared that he is likely to make less conventional more individualized responses to stimuli, which may be the result of an orientation to maintain distance from and thus cope with an environment perceived as threatening, demanding or unyielding. In addition he appeared to have significant problems with perceptual accuracy. It appeared likely that irritating or painful affect was contributing to the perceptual and/or mediational difficulty he experienced.

#### SUMMARY

Derrick was a 10 year old male who appeared to have very low self esteem and who appeared to be experiencing irritating or painful affect that was interfering with his perceptual and/or mediational activities. He displayed a marked tendency to narrow or simplify stimulus fields and to hastily or haphazardly scan his environment. Because he may miss, neglect or distort critical cues or bits of information, this style can create the potential for a higher frequency of behaviors that do not coincide with social demands or expectations. It also appeared that Derrick was likely to have difficulty in modulating affect and is more inclined to display feelings and be less

concerned about modulating or controlling those displays. He may have a sense of hopelessness or discouragement about his relationships to the world and may expect gloomy outcomes regardless of his efforts. Some of his responses suggested that problems with impaired perceptual accuracy could be due either to attentional and concentration problems, neurological problems or decompensation and internal preoccupation related to depressive affect. He did give an unusually large number of responses to portions of the testing, which can be associated with a Bipolar process. This along with the significant impairments in his cognitive processing suggest that he will need to be monitored for the possible development of more significant affective and cognitive disturbances. Also further testing could rule out the presence of neurological problems.

#### DIAGNOSTIC IMPRESSIONS

Axis 1      Oppositional Defiant Disorder  
                    Depressive Disorder, NOS  
                    features of Attention Deficit Disorder  
Axis II      see Educational assessment  
Axis III      rule out seizure disorder  
Axis IV      moderate  
Axis V      35 on admission

#### RECOMMENDATIONS

1. Individual, group and family therapy is indicated, with a focus on a structured behavioral program.
2. Derrick is in much more significant distress than he indicate verbally. Because his verbal skills appear to be less well developed, Derrick will need significant help in learning ways to successfully deal with his feelings. Interventions should be made on a more concrete level. As observed in the testing, writing and drawing appear to be more comfortable modalities for Derrick and could be utilized in helping him learn more appropriate coping behaviors.
3. He will need self esteem building activities.
4. He would benefit from activities that provide structured practice in increasing his purposeful attention and concentration.
5. Because there was some question as to whether he was accurately hearing the examiner at times, a hearing exam if it has not been done, or a speech and language assessment could be considered.

6. Despite his hesitance to verbalize, Derrick does appear to want positive interactions and does appear motivated to succeed and do well.

Karen Auln DPT

Psychologist